Health New England: HNE HMO Essential 500

Coverage Period: 07/01/2015 – 06/31/2016

Summary of Benefits and Coverage: What this Plan Covers & What it Costs **Coverage for:** Individual + Family| **Plan Type:** HMO

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.hne.com or by calling 800.310.2835.

Important Questions	Answers	Why this Matters
What is the overall deductible?	$500 person /$1,000 family – Doesn't apply to preventive care.	You must pay all the costs up to the deductible amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the deductible starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the deductible.
Are there other deductibles for specific services?	Yes. $25 per child for out-of-plan children's dental exams.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
Is there an out-of-pocket maximum on my expenses?	Yes. $5,000 person / $10,000 family	The out-of-pocket maximum is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out-of-pocket maximum?	Premiums; healthcare this plan does not cover; your cost sharing for benefits that are not Essential Health Benefits under national health care reform; out-of-plan children's dental exams	Even though you pay these expenses, they don't count toward the out-of-pocket maximum.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for specific covered services, such as office visits.
Does this plan use a network of providers?	Yes. See hne.com or call 800.310.2835 for a list of participating providers.	If you use an in-plan doctor or other health care provider, this plan will pay some or all of the costs of covered services. Be aware, your in-plan doctor or hospital may use an out-of-plan provider for some services. Plans use the term in-plan, in-network, preferred, or participating for providers in their network. See the chart starting on page 2 for how this plan pays different kinds of providers.
Do I need a referral to see a specialist?	No.	You can see the specialist you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about excluded services.

Questions: Call 800.310.2835 or visit us at hne.com.

If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.dol.gov/ebsa/healthreform or call 800.310.2835 to request a copy.

- **Copays** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-plan **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-plan hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use in-plan **providers** by charging you lower **deductibles**, **copays** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your cost if you use an In-plan Provider	Your cost if you use an Out-of-plan Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$20/visit	Not covered	Deductible may apply to some office services.
	Specialist visit	$20/visit	Not covered	Deductible may apply to some office services.
	Other practitioner office visit	$10 for chiropractor	Not covered	Limited to 12 visits per year.
	Preventive care / screening / immunization	No charge	Not covered	Routine eye exams limited to 1 per year. Routine gynecological exams limited to 1 per year. Routine mammograms limited to 1 per year. Screening colonoscopy limited to 1 every 5 years. Nutritional counseling limited to 4 visits per year.
If you have a test	Diagnostic test (x-ray, blood work)	No charge (x-ray subject to deductible)	Not covered	----------none----------
	Imaging (CT/PET scans, MRIs)	$75 after deductible; maximum 3 copays per year	Not covered	Requires prior approval.
If you need drugs to treat your illness or condition.	Generic drugs	$10 retail, $10 mail order / prescription	Not covered	Covers up to a 30 day supply (retail); 90 day supply (mail order). Some drugs require prior approval by HNE.

Common Medical Event	Services You May Need	Your cost if you use an In-plan Provider	Your cost if you use an Out-of-plan Provider	Limitations & Exceptions
More information about prescription drug coverage is available at hne.com.	Formulary brand drugs	$25 retail, $25 mail order / prescription	Not covered	Covers up to a 30 day supply (retail); 90 day supply (mail order). Some drugs require prior approval by HNE.
	Non-Formulary brand drugs	$45 retail, $45 mail order / prescription	Not covered	Covers up to a 30 day supply (retail); 90 day supply (mail order). Some drugs require prior approval by HNE.
	Specialty drugs	Copay depends on drug category.	Not covered	Some drugs require prior approval.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center) and Physician/surgeon fees	No charge after deductible	Not covered	Some services require prior approval; office visit copay may apply if done in a doctor's office.
If you need immediate medical attention	Emergency room services	$150/visit	$150/visit	----------none----------
	Emergency medical transportation	$100/Member/day after deductible	$100/Member/day after deductible	----------none----------
	Urgent care	$20/visit	Not covered	Deductible may apply to some office services.
If you have a hospital stay	Facility fee (e.g., hospital room) and Physician/surgeon fees	No charge after deductible	Not covered	----------none----------
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$20/visit	Not covered	----------none----------
	Mental/Behavioral health inpatient services	No charge after deductible	Not covered	----------none----------
	Substance use disorder outpatient services	$20/visit	Not covered	----------none----------
	Substance use disorder inpatient services	No charge after deductible	Not covered	----------none----------
If you are pregnant	Prenatal and postnatal care	No charge	Not covered	Deductible and copays may apply for non-routine services.

Common Medical Event	Services You May Need	Your cost if you use an In-plan Provider	Your cost if you use an Out-of-plan Provider	Limitations & Exceptions
	Delivery and all inpatient services	No charge after deductible	Not covered	Coverage for child limited to routine newborn nursery charges. For continued coverage, child must be enrolled within 30 days of date of birth.
If you need help recovering or have other special health needs	Home health care	No charge after deductible	Not covered	Requires prior approval.
	Rehabilitation services	$20/visit per treatment type after deductible	Not covered	Limited to two months or 25 visits, whichever is greater, per condition per calendar year for physical or occupational therapy.
	Habilitation services	No charge	Not covered	Early intervention services covered for children from birth to age 3.
	Skilled nursing care	No charge after deductible	Not covered	Limited to 100 days per calendar year.
	Durable medical equipment	20%	Not covered	Some items require prior approval.
	Hospice service	No charge	Not covered	Requires prior approval.
If your child needs dental or eye care	Eye exam	No charge for routine exams	Not covered	Routine exams limited to one per calendar year.
	Glasses	Not covered	Not covered	----------none----------
	Dental check-up	No charge	You pay the first $25 per child per calendar year.	For children under age 12. Out-of-Plan dentists may also bill you for the difference between their charge and HNE's contracted dental network allowed amount.

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Acupuncture
- Cosmetic Surgery
- Dental care (except for the limited services specified in your plan materials)
- Glasses
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine foot care (routine foot care is covered if you have diabetes)
- Weight loss programs

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Bariatric surgery (requires prior approval)
- Chiropractic Care
- Hearing aids – limited to members age 21 and under, $2,000 per hearing aid per ear each 36 months.
- Infertility treatment (requires prior approval)
- Routine eye care

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 800.310.2835. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 866.444.3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 877.267.2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact:

- HNE Member Services at 800.310.2835.
- U.S. Department of Labor's Employee Benefits Security Administration at 866.444.EBSA (3472) or dol.gov/ebsa/healthreform.
- Massachusetts Division of Insurance at 617.521.7777.

Additionally, a consumer assistance program can help you file your **appeal**. Contact:

Health Care for All
30 Winter Street, Suite 1004
Boston, MA 02108
800.272.4232

or www.massconsumerassistance.org

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $6,970
- **Patient pays** $570

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$500
Copays	$70
Coinsurance	$0
Limits or exclusions	$0
Total	**$570**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $4,500
- **Patient pays** $900

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$0
Copays	$900
Coinsurance	$0
Limits or exclusions	$0
Total	**$900**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copays**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copays**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

Questions: Call 800.310.2835 or visit us at **hne.com**.
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